State of California Department of Consumer Affairs

CALIFORNIA STATE ATHLETIC COMMISSION
1424 HOWE AVE. STE. #33
SACRAMENTO, CA 95825
INTERNET: www.dca.ca.gov
(916) 263-2195 FAX (916) 263-2197

APPLICATION FOR AMATEUR KICKBOXER

The following items must be submitted with the application or it will be returned.

- ☐ One (1) passport sized photograph (2"x 2").
- ☐ Physical Examination Report by licensed physician.

Full Name: (Please Print) Last First Middle				
Address: Street City State Zip Code				
( ) Telephone Number			Social Security Number (Mandatory)	
Age	M / F (Circle One)	Date of Birth	ft. in. Height	lbs. Ring Weight

Have you ever been convicted of any offense other than minor traffic violations? ☐ YES ☐ NO (You must answer "Yes" even if a conviction or plea of guilty was changed, withdrawn, dismissed, discharged, set aside or pardoned under Section 1203.4 of the Penal Code). If answer is "Yes", please explain and attach copy of conviction_____

Are you now on parole or probation? ☐ YES ☐ NO
Name of Parole or Probation Officer: _____

Have you previously applied for licensure as an amateur boxer? ☐ YES ☐ NO
Where: _____

Have you ever had any license revoked, suspended, been disciplined or fined? ☐ YES ☐ NO
If answer is yes, please explain: _____

Have you ever used any other name(s)? ☐ YES ☐ NO If answer is yes, list name(s) _____
_____

EXPERIENCE:

How long have you been in training:
_____

Where do you train? _____

How many bouts have you had:
_____

Have you ever participated in a professional boxing contest? ☐ YES ☐ NO If so, where? _____

Where did you box before coming to this State? _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name:

_____

Address:

_____

City: _____State: _____Zip Code:_____

Authority to provide the California State Athletic Commission with this information is established pursuant to Sections 18640, 18642 and 18643 of the Business and Professions Code. Disclosure of your social security number is mandatory pursuant to Section 30 of the Business and Professions Code and Pub. L.94-455 (42 USCA 405 (c) (C) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code. If you fail to disclose your social security number, your application for initial or renewal license will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you. **All items in this application are mandatory; none are voluntary**. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

APPLICANT'S SIGNATURE: _____ DATE: _____

This item is VOLUNTARY. You do not have to check this box.

[ ] I hereby authorize the California State Athletic Commission to release my telephone number to any commission licensee. This authorization shall be valid only during the calendar year in which this application is signed.

OFFICE USE ONLY

License # _____

Received By: _____

Date App Received: _____

Check Number: _____

P/E Date: _____

APPROVE FOR LICENSE

_____

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AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME | RING NAME | TELEPHONE | DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP CODE | COUNTRY

PHYSICAL HISTORY: Have you ever had any of the following conditions:
☐ Fainting spells ☐ Rupture (hernia) ☐ Chest pains ☐ Operations ☐ Shortness of breath ☐ Swollen joints
☐ Rheumatism ☐ Diabetes ☐ Frequent headaches
☐ Convulsions (fits) ☐ Chronic cough ☐ Spitting of blood
☐ Cerebral hemorrhage or serious head injury ☐ None
No. of knockout losses in your career _____ Date of last knockout _____
Have you ever suffered a loss of consciousness for any reason? ☐ YES ☐ NO
If so, please explain and provide date(s) and location(s): _____
_____
When was the last time you took any type of medication or drug? (State what type and when)
_____
Have you ever undergone any type of surgery? ☐ Yes ☐ No If so, please describe.
_____
When was the last time you took any type of vitamin supplement? (State what type and when)
_____
Amateur record: Wins _____ Losses _____ Draws _____
Professional boxing/martial arts record: Wins _____ Losses _____ Draws _____
Additional information:_____

PHYSICAL EXAMINATION:
General appearance: _____ Height: _____ Weight: _____ Temperature: _____
Disabling scars: _____ Mouth: _____ Teeth: _____ Tonsils: _____ Neck: _____
Pulse at rest: _____ Pulse after 100 hops: _____
Blood pressure: At rest: _____ After 100 hops: _____ 2 minutes later: _____
Enlarged glands: ☐ Yes ☐ No - Goiter: ☐ Yes ☐ No
Heart: Pulse rhythm ☐ Regular ☐ Irregular – Murmurs: ☐ Yes ☐ No
Apical impulse: ☐ Heavy ☐ Normal - Enlargement: ☐ Yes ☐ No
Lungs: Rales ☐ Yes ☐ No - Abdomen: Enlargement of liver ☐ Yes ☐ No
Breasts: Mass ☐ Yes ☐ No – Tenderness ☐ Yes ☐ No – Discharge ☐ Yes ☐ No
Enlargement of Spleen: ☐ Yes ☐ No – Hernia: ☐ Yes ☐ No
Femoral ☐ Inguinal ☐ Ventral – Testicles: Normal ☐ Yes ☐ No
Remarks:_____
Reflexes: Pupils _____ Knee jerks _____ Romberg _____
Babinski _____ Skin: Tone _____ Rash _____ Boils _____ Other:_____
Unhealed wounds: _____
Remarks: _____

EYE HISTORY: Have you ever had any of the following conditions:
Blurred vision? ☐ Yes ☐ No – If YES, please explain in full:_____
_____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye?
☐ Yes ☐ No – If YES, please explain in full: _____
_____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ☐ Yes ☐ No – If YES, please explain in full:
_____
_____

EYE EXAMINATION:

Vision without glasses Right _____ Left _____
Vision with glasses Right _____ Left _____
Visual fields Right _____ Left _____

EXAMINING PHYSICIAN:
I have examined the above named applicant and I ☐ **DO NOT FIND** ☐ **DO FIND** a condition that would preclude him/her from being licensed as a professional ☐ boxer, ☐ kickboxer, or ☐ martial arts athlete**.**

The California State Athletic Commission is a health care oversight authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by Business and Professions Code Section 18600, et seq to collect information about the applicant's physical condition. Authorization for release of medical information is attached.

_____ _____
LICENSED PHYSICIAN'S NAME (print) **MEDICAL LICENSE NUMBER**

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____
TELEPHONE NUMBER **DATE/TIME**

_____
PHYSICIAN'S SIGNATURE

Office Use

Approved By: _____

Date: _____

Revised 01/2007